



Claim for Death Benefits
Federal Employees' Group Life Insurance Program
Information Regarding Claim for Death Benefits (Form FE-6)



Instructions to claimant

General

Please read the following instructions carefully, and type or print in ink.

If you need assistance in completing this claim, contact the deceased's last employing office, or the Office of Federal Employees' Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188. You may call the OFEGLI service representatives, toll-free, at 1-800-OFE-GLIA (1-800-633-4542) or (212 578-2975.)

The information requested on this form is needed by the Office of Federal Employees' Group Life Insurance to adjudicate your claim for benefits under the Federal Employees' Group Life Insurance Program as authorized by chapter 87, title 5, U.S. Code. Interest payments, if any, are considered as income for Federal Income Tax purposes. Interest will be reported to the Internal Revenue Service in accordance with the provisions of Sections 6041 and 6042 of the Internal Revenue Code of 1954. Provision of the information is voluntary; however, failure to supply all of the requested information may delay or prevent action on your claim.

Order of precedence

Payment of life insurance and accidental means death benefits under the Federal Employees' Group Life Insurance Program shall be made in the following order of precedence:

- First, to the beneficiary designated by the insured;
- Second, if there is no such beneficiary, to the widow or widower;
- Third, if none of the above, to the child or children of the insured, with the share of any deceased child distributed among descendants of that child;
- Fourth, if none of the above, to the parents of the insured in equal shares, or the entire amount to the surviving parent;
- Fifth, if none of the above, to the executor or administrator of the insured's estate;
- Sixth, if none of the above, to the other next of kin of the insured entitled under the laws of the domicile of the insured at the time of death.

Completion of the claim

Each claimant must submit a separate claim form.

All claimants must answer Part A--General Information About the Deceased. If you were designated in writing on Standard Form 2823 (formerly Standard Form 54) as a beneficiary, you need not answer Parts B through . Otherwise, it is important that all questions be answered. Omissions or incomplete answers will delay settlement of your claim. If the answer to any question is "No" or "None," so state. In any event, be sure to fill out the information under Special Note on page 2 and complete part F on page 4.

Evidence required

You must submit a certified copy of the death certificate with this claim. The certificate may be obtained from the

Bureau of Vital Statistics or equivalent agency. Failure to submit a certified copy of the death certificate will delay settlement of your claim.

In addition, if the insured designated a beneficiary and a receipted copy of either Standard Form 2823 or Standard Form 54 "Designation of Beneficiary" is available, you should submit this form with your claim.

If an executor or administrator is filing this claim on behalf of the estate of the deceased, a copy of the court appointment papers must be submitted.

You will be informed if it becomes necessary to submit other evidence.

Manner of payment

If the amount payable to you is less than \$7,500, you will receive a single check for the entire amount.

If the amount payable to you is \$7,500 or more, MetLife-the administrator of the FEGLI Program-will open a Money Market Option Account in your name. You will receive a checkbook giving you complete control of and immediate access to all of your funds. You may write checks for all or part of the money in your Account beginning the first day you receive your checkbook. The Money Market Option Account offers a number of benefits which are explained on page 2.

Where to send the claim

If the insured was employed at the time of death

Send your completed claim to the employing office of the department or agency where the insured was last employed. That office must certify the decedent's insurance status at the time of death.

If the insured was retired or receiving Federal Workers' Compensation benefits at the time of death

Send your completed claim to the Office of Federal Employees' Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188.

The claim will be adjudicated upon receipt of insurance certification from the Office of Personnel Management, Retirement and Insurance Group, Retirement Operations Center, Boyers, PA 16017.

Instructions to the employing agency

It is the agency's responsibility to assist the insured's beneficiary or next of kin in properly completing this claim.

The agency should forward the completed claim and all required supporting evidence to the Office of Federal Employees' Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188, together with:

1. The original of the Agency Certification of Insurance Status (SF 2821);
2. The original of all Designation of Beneficiary forms (SF 2823 or SF 54), if any;
3. Any other documents (except payroll records) bearing on the deceased employee's insurance status.

**IMPORTANT INFORMATION ABOUT THE
FEATURES OF YOUR MONEY MARKET OPTION ACCOUNT**
DESIGNED TO PUT YOU IN COMPLETE CONTROL OF YOUR LIFE INSURANCE PROCEEDS
YOUR MONEY MARKET OPTION ACCOUNT PROVIDES...

SAFETY

- The account earns interest from the first day it is established.
- The full amount, including all interest earned, is guaranteed.

COST FREE CHECKING

- You pay nothing for this Account. There are no monthly service charges. No charge for checks.
- You can write checks from \$250 up to the full amount of your proceeds at any time.

FLEXIBILITY

- You can withdraw all or part of your money at any time; with no penalty or loss of interest.
- You can name a beneficiary for your funds, in case something happens to you.

Safety · Security · Privacy · Flexibility · Free Checking

SPECIAL NOTE

**PLEASE BE SURE TO COMPLETE, IN INK, THE
INFORMATION REQUESTED BELOW AND SIGN YOUR
NAME IN THE APPROPRIATE BOX.**

Signature of claimant <i>(Do not print)</i>											
Name of claimant <i>(Please print)</i>											
Address <i>(Number, street, apt. no.)</i>											
City, State, ZIP code											
Social Security Number OR Employer identification number				-			-				
				-			-				
Date	Daytime telephone no.					Evening telephone no.					
	Area Code					Area Code					

Office of Federal Employees' Group Life Insurance 200 Park Avenue New York, NY 10166-0188		<h2 style="margin: 0;">Claim for Death Benefits</h2> <p style="margin: 0;">Federal Employees' Group Life Insurance</p>	Read the instructions carefully before filling out this form.
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Part A. General Information About the Deceased

1. Full name of the deceased (Last) (First) (Middle)	2. Date of birth (Month, day, year)	3. Date of death (Month, day, year)
4. Social Security Number	5. Department or agency in which last employed, including bureau or division	6. Final separation date, if different from date of death (Month, day, year)
7. Location of last employment (City, State, ZIP Code)	8. Legal residence at time of death-(City and State)	9. Was the deceased on active duty in the U.S. military forces at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
10. Was the deceased retired and receiving annuity under any Federal civilian retirement system, including Social Security, or receiving Workers' Compensation at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Claim number Effective date
If the deceased named you as beneficiary on a Designation of Beneficiary Form under the Federal Employees' Group Life Insurance Program (Standard Form 2823 or Standard Form 54), attach a receipted copy of that form to the claim, give your date of birth and relationship in the boxes to the right, and complete Part F on the other side. If a receipted copy of either Standard Form 2823 or Standard Form 54 is not attached, you must complete all parts of this claim form, as payment may be considered under the order of precedence.		Your date of birth (Month, day, year) Relationship to the deceased

Part B. Personal Information Concerning the Deceased

1. How many times was the deceased married?	3. Give the name of each spouse (include all marriages)	4. How was marriage terminated? <i>(Check one in each case)</i> <input type="checkbox"/> Death <input type="checkbox"/> Divorce	5. Date marriage was terminated (Month, day, year)
2. Was the deceased survived by any children?		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Death <input type="checkbox"/> Divorce	

Part C. Information Concerning the Claimant

1. Your name (Last) (First) (Middle)	2. Your relationship to the deceased	3. Your date of birth (Month day year)
Items 4 through 13 must be filled in if you are the widow or widower of the deceased.		
4. Date of marriage (Month, day year)	5. Place of marriage (City and State)	6. Marriage was performed by: <input type="checkbox"/> Clergy or Justice of the Peace <input type="checkbox"/> Other (specify)
7. Were you living with the deceased at the time of death?	8. If you were not living with the deceased at the time of death was there a divorce?	9. If you were divorced from the deceased, give the date (Month, day, year) and place of the divorce.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. How many times were you married?	11. Give the name of each spouse (include all marriages)	12. How was marriage terminated? <i>(Check one in each case)</i> <input type="checkbox"/> Death <input type="checkbox"/> Divorce
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce
		<input type="checkbox"/> Death <input type="checkbox"/> Divorce
		13. Date marriage was terminated (Month, day, year)

(continued on the other side)

Fill in Parts D and E only if you are not the designated beneficiary or the widow or widower of the deceased.

Part D. Information Concerning Next of Kin of the Deceased

1. List below the name, age, relationship, and address of:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>(a) Widow or widower;</p> <p>(b) If there is no surviving widow or widower, list the child or children of all the deceased's marriages (include adopted or illegitimate children, stating relationship) and the descendants of any deceased child or children;</p> | <p>(c) If there are no children, list the parents; if one or both parents are deceased, so state and give the date of death;</p> <p>(d) If there are no survivors as indicated in (a) through (c), list the next of kin who may be capable of inheriting from the deceased (brothers, sisters, descendants of deceased brothers, sisters, etc.).</p> |
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Name	Age	Relationship to the deceased	Full address

Fill in items 2 and 3 only if any of the persons listed above are under age 18.

2. If a guardian has been appointed by the court for the estate of any minor children above, give the name and address of the guardian and attach a copy of the appointment papers issued by the court. Natural parentage or custody as a result of a divorce does not constitute guardianship.	Name	3. If a guardian for the estate of any minor children has not been appointed, will one be appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address (<i>Number, street, apt. no.</i>)	
	City, State, ZIP Code	

Part E. Information Concerning the Estate of the Deceased

1. If an executor or administrator has been approved by the court to settle the estate of the deceased, give his/her name and address and attach a copy of the court appointment papers.	Name	2. If an executor or administrator has not been appointed, will one be appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address (<i>Number, street, apt. no.</i>)	
	City, State, ZIP Code	

Part F. Certification by the Claimant

Is a claim being made for accidental means death benefits (injuries solely sustained through violent, external, and accidental means)? If "Yes" submit coroner's and police reports, news clippings, and any other available reports concerning the accident. No claim for such benefits can be considered if the date of the insured's separation or retirement is prior to the date injuries were sustained which caused the death of the insured. <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>		
Backup Withholding Has the IRS notified you that you are subject to backup withholding as a result of a failure to report all interest or dividends? <div style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </div>		
If your benefits are less than \$7,500, payment will be made to you by a single check. If the amount payable to you is \$7,500 or more, a Money Market Option Account--as described on page 2-- will be opened in your name giving you complete control of and immediate access to all of your funds. You may write checks for all or part of the money in your Account when you receive your checkbook.	Please be sure to also complete the information requested on page 2 under "Special Note"	Date
	Signature of claimant (<i>Do not print</i>)	
	Name of claimant (<i>Please print</i>)	
I hereby certify under the penalties of perjury that all statements made in this claim are true, correct and complete to the best of my knowledge, information, and belief, and that no evidence necessary to settle this claim is suppressed or withheld.	Address (<i>Number, street, apt. no.</i>)	
	City, State, ZIP Code	
	Social Security Number OR Employer identification number	Daytime telephone no. Area Code